FY 2009   Agreement Number _____
Form 1   Sponsor Name   _____

KENTUCKY DEPARTMENT OF EDUCATION
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
MANAGEMENT PLAN – PART III
Budget and Administration Support Documentation

1. Does your agency receive Title III meal funding or commodities?
   ____Yes ____No _____N/A

2. Does your agency participate in any other public funding (state or federal)? _____Yes _____No If **"Yes"**, what is the source?
   _____

3. Has your agency **ever** been determined ineligible to participate in another publicly funded program? _____ Yes _____ No If **"Yes"**, identify program and circumstances.
   _____

4. Do you operate multi-state offices? _____Yes _____No _____N/A
   If **"Yes"**, give sponsor office address(es), number of sites by type (centers, FDCH), and areas served by each state office.

   _____

   List the other state(s) in which you operate, and state how long you have been in business in each state.

5. Have any of your agency's employees/board members **ever** served as employees/board members for any agency terminated from the CACFP? _____ Yes _____ No
   (If **"Yes"**, please identify employees/board members and the terminated agency.)
   _____

6. Have any changes occurred in your agency's administrative structure/operation during the past fiscal year? _____ Yes _____ No
   (If **"Yes"**, please describe.)
   _____

7. Does your agency contract for goods or services with any employee, board member or member of their immediate family? _____ Yes _____ No
   (If **"Yes"**, please identify contracts and employees, board members and immediate family members involved.)

Form – 1A   Sponsor Name _____

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8. Does your agency utilize a CPA firm or bookkeeping service for accounting purposes?
    _____Yes _____No
    (If **"Yes"**, please identify the name, address, and phone number of the CPA firm or
    bookkeeping service).
    _____

9. Does your agency have any outstanding debt resulting from a **civil judgment** by a local,
    state or federal court or regulatory agency? _____Yes _____No (If **"Yes"**, please describe.)
    _____
    _____

10. Does your agency have any outstanding debt resulting from the non-payment of payroll
    taxes to the IRS? _____ Yes _____ No
    (If **"Yes"**, please describe.) _____
    _____

**As part of the demonstration that your sponsor/center is financially viable, the State
Agency is requesting information on your submission of required taxes to the state and
federal government.**

11. Provide copies of the last monthly and quarterly taxes submitted by your agency: FICA,
    Medicare, Federal Withholding, Unemployment (Federal and State), State Withholding
    (K-1), City/County withholding, business tax, other, etc. (If new business, give date that
    taxes will be submitted and send a copy to our office when filed.)

    Identify required taxes and date tax reports and payment submitted:
    _____
    _____

12. If your agency is a private non-profit entity, has the Form 990 been completed and
    submitted to the IRS as required during the last year? _____ Yes _____ No
    (If **"No"**, please describe.) The Sponsor must submit the agency's most recent Form 990
    to the State Agency.

13. Describe your policies and procedures for resolving violations of CACFP policies by
    sponsored facilities. (Submitted documentation should include only policies and procedures
    that applies to the CACFP).

    _____
    _____
    _____
    _____
    _____
    _____
    _____

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14. **For All Sponsors:** Sponsors are required to establish at least one office located no more than 100 miles from each provider sponsored by your agency. Staff must be available during
regular working hours.

Also, no more than 50 providers may be assigned to each staff monitor, unless otherwise requested and approved in writing by the State Agency.

Sponsor office physical locations

Provide the physical address, phone number, hours of operation, and the name(s) of the monitor(s) assigned for each office.

Office 1	Office 2
Office 3	**Office 4**
Office 5	**Office 6**

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15. Describe your system for ensuring that **existing** providers receive annual training on all required program topics, how documentation is maintained to show the name of each provider trained, and the training date for each provider. (If your answer is long, please submit an attachment, and **label it #15**.) _____

_____

16. Describe your system for training all **new** providers before they begin participation in the CACFP. (If your answer is long, please submit an attachment, and **label it #16**.

_____
_____
_____

17. The Sponsor will be using **review Averaging** for FY 2008-2009. Yes _____ No _____ Please provide an explanation as to how you plan to implement review averaging. (If answer is long, please submit attachment, and **label it #17**.)

18. The Sponsor has a written Seriously Deficient Policy for those providers who are noncompliant. Yes _____ No _____ Please submit a copy of the Seriously Deficient Policy and **label it #18**.

19. The Sponsor has a procedure in place for identifying potential fraudulent situations, i.e. block claiming, excessive meals claimed for supper and weekends, etc. and follows up on potentially fraudulent situations. Yes _____ No _____

20. The sponsor has procedures in place for contacting households (mail, telephone, survey, etc.) to evaluate the accuracy of provider claims. Yes _____ No _____

21a. Please submit a copy of the Sponsor's Household Contact Policy and **label it #21A**.

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22. Staffing pattern for CACFP: Complete for personnel who will be involved in administering the CACFP. Administrative duties include managing and operating the CACFP.			
Employee Name – Position	Date of Birth	Specific CACFP Administrative Duties	% of Time for CACFP

23. In the table below, list employees involved with monitoring as defined below. For each employee, indicate percentage of CACFP hours spent on monitoring. Monitoring ratios for sponsors must equal at least one FTE (2080 hrs/yr. or 173 hrs/mo). See below for more detail.

Employee Name	*Total hours per month spent on CACFP (from table above)	% CACFP hours spent monitoring	**Description of Monitoring Activities

*A full-time equivalent equals one staff year (2080 hours) or a staff month (173 hours) and could be one full-time staff person who monitors full time; two half-time staff who spend all of their time monitoring; two full-time staff who spend half of their time monitoring; three full-time staff, one of which monitors 40% of the time, with the other two each spending 30% of their time monitoring, etc.

**Monitoring activities include, but are not limited to: conducting on-site reviews, supervisory oversight of monitors; writing review reports; follow-up reviews; parental contact; training; and claims processing.

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24. Submit a listing of all providers that meet the following criteria:

    a) Live outside Tier I eligible areas who claim eligibility for Tier I reimbursement
       for all children based on the provider's Food Stamp eligibility;

    b) Live in eligible areas who have established their child's eligibility for Tier I
       reimbursement based on the provider's Food Stamp participation.

Please ensure that the provider name, address, and Food Stamp case number are included. Label
this as **attachment #24**.